Notes on the British Health Plan*

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IT IS the job of a public servant not only to carry out the responsibilities placed on him by the President and the Congress, but also to prepare himself for new responsibilities which may be in the offing. President Truman has repeatedly asked Congress to establish a program of National Health Insurance for the United States. This proposal has become a matter of increasing interest and controversy among both doctors and the general public. Out of this continuing discussion, and under pressure of the nation's health needs, I believe that in time National Health Insurance will inevitably be established. When this happens, responsibility for making sure that its administration conforms with Congressional desires will undoubtedly be handed to the Federal Security Administrator. It was for this reason that, in the course of my recent visit to Europe, I made a study of the health plans in the various countries visited.

Our visits to each country on our itinerary were necessarily brief, and I do not pretend to have made a detailed, exhaustive study. Seeking the answers to several basic questions, we talked with physicians, hospital administrators, officers of medical associations, and government officials; and made personal visits to doctors' offices, clinics, hospitals, and research institutions. In making this survey, I had the benefit of the technical advice of Dr. W. Palmer Dearing, Deputy Surgeon General, and Dr. David E. Price, Chief of the Division of Research Grants and Fellowships, both of the Public Health Service.

We examined health programs in Britain, Ireland, Sweden, Switzerland, Italy and Israel. Of these, the British health service has been most often in the news and is perhaps of greatest significance in connection with proposals now under consideration here.

By far the biggest single question that should be asked in exploring any such program is whether it is in fact good for the public at large. If this basic aim is not achieved, then the finest plan in the world is not worth establishing. I put the question squarely to several groups of general practitioners and specialists, both in London and Edinburgh, as well as to the officers of the British Medical Association. Without exception—and despite their professional criticisms of the way in which the service was being administered—they told us that beyond question the program was a good thing for the British people. They denied that, so far as the patient was concerned, the quality of medical care had deteriorated in any way; and they insisted that for the individual patient there was, for the first time, full opportunity to receive the attention which many had not been receiving prior to July 1948.

This does not mean that all doctors in Britain are satisfied with the program. Their opposition, up to the summer of 1948, had been intense. Today the majority of British doctors seem to feel that, in general, the plan has worked out rather well. I put this question to every doctor we met: "If you had the power to turn the clock back, and revert to the old method of practicing your profession, would you do it?" Of all the physicians to whom we talked, only one said he would. And he went on to explain that he was familiar with President Truman's proposal for National Health Insurance in the United States, and that if it had been put into practice in Britain in place of the present one, all of his objections would have been met.

Obviously, these conversations with doctors were not scientific samplings of public opinion. But I honestly believe that they reflect the majority viewpoint of the British medical profession today. At the same time, some very serious criticisms were made of the program in practice. Some of the more important are worth itemizing:

1. There was widespread criticism of the fact that, when the plan went into effect, the Govern-

* A summary of points made by Mr. Ewing in recent informal talks before various Federal agencies and in an address at the annual dinner of the Kappa Pi Honorary Medical Society, Howard University, on March 24.

ment took over, with a few exceptions, all hospitals in the British Isles. This is said to have caused many administrative problems, without at the same time providing enough counterbalancing advantages. Our health insurance plan in this country would avoid these problems, because there is absolutely no intention of the Federal Government taking over the hospitals.

2. There was much criticism of the rapidity with which the plan was put into effect in Britain. This is believed to have created confusion in the early months of operation. British physicians were anxious that we should learn from this experience, and not rush into full operation the moment Congress enacted a health insurance law. As it happens, the President's proposal provides for a three-year "tooling-up" period in order to avoid this very difficulty.

3. Many doctors were dissatisfied with existing methods of payment in Britain. Most doctors are working somewhat harder than before the service went into effect, and their income has not suffered. But there is some feeling that doctors who deliberately spend more time with individual patients are discriminated against and that doctors who treat the full maximum of patients allowed by law (4000) are greatly favored. They also feel that it is somewhat more difficult for young doctors to establish themselves than was formerly the case. The information we received regarding methods of payment—especially in terms of the so-called capitation fee—has caused us to conclude that there should be certain revisions in our thinking in this connection, so as to avoid the discriminations which were pointed out in Britain. For example, a staggered capitation fee, with larger payments for an initial group of patients and smaller payments for each succeeding group, might go far to solve this problem. It might also benefit the beginning doctor, although we were inclined to believe that his difficulty in England stemmed largely from the abolition of the traditional British system of buying and selling practices—a system which is quite rare in the United States.

4. It was widely felt that furnishing all drugs and medicines—formerly at no cost, and now at a flat nominal cost of one shilling (14¢)—had led to certain abuses and to unnecessary drain on doctors' time. The American plan would provide for free medicines only when they are of the expensive variety, such as streptomycin, and patients would continue to pay for the less costly drugs and medicines exactly as they do now. Most of the British doctors feel that this is a sound policy for us.

In addition to such specific criticisms as these, we found a certain tendency to criticize the British health program on philosophical grounds. There is no question but that the British plan was designed to be in keeping with the Labor Party's over-all nationalization program. The taking over of the hospitals—something that no one even suggests in the United States—is a striking example of this intention. Those who oppose this political aim were, of course, prone to be critical of the basic thinking involved here—although it was significant that in the recent elections the Conservative Party carefully refused to make the health program a political issue, because of its popularity with the public at large.

In the United States, however, the President's program for National Health Insurance is not in any way intended to change our economic, social or political structure. It is simply an insurance program which would remove the dollar barrier which prevents so many Americans from receiving the medical care they need. The Swedish health program is, like the British, an outgrowth of conscious desire to create a more highly nationalized society; but the Swiss system lies entirely within the concept of a free economy. In neither the Swedish nor the Swiss case, however, do the methods entirely apply to the problems we face in the United States, primarily because our country is so large and our population so heterogeneous.

The two most important impressions I brought back with me from Britain were, first, that the new health program had in fact benefited the British people, and second, that our own technicians had foreseen many of the British mistakes in drawing up the detailed legislation based on President Truman's proposals.

Dr. Charles Hill, Secretary of the British Medical Association and now a Conservative Member of Parliament, remarked to me that "the things we worried about most at the outset turned out to be rather unimportant, and the things we didn't even think about have turned out to be very important."

I believe that, when National Health Insurance

is adopted in the United States, we will have been able to benefit greatly by the European experience—and to develop for our country an American program designed to meet American needs within the American tradition of social insurance. And I am certain that the American medical profession will in the long run recognize that National Health Insurance can in fact be the greatest boon to the healing art since the discovery of anesthesia.

MEDICAL COVERAGE PROVIDED BY BLUE SHIELD AND PROPOSED NATIONAL HEALTH INSURANCE PLANS*

Item	*Blue Shield*	*N.H.I.*
People protected	9%	85%
Amount of Protection		
Doctor at Home	No	Yes
Doctor at Office	Rarely	Yes
Expensive Drugs	No	Yes
Preventive Medicine	No	Yes
Surgeon and Specialist	Yes (partial)	Yes
Hospitalization†	Yes	Yes
Public Control	No	Yes
Annual Cost Per Average Family of Blue Shield and Blue Cross Together	$80-$85	$48

* According to data released by the Committee for the Nation's Health.
† Almost all Blue Shield members also hold membership in Blue Cross hospital plans, which insure them against most hospital charges.

BLUE SHIELD MEDICAL INSURANCE PLANS
PERCENTAGE OF POPULATION ENROLLED, BY STATES, JANUARY 1, 1950*
Total National Enrollment—13,500,000, 9% of U. S. Population

Percent of Population Enrolled	*Number of States*	*List of States*			
Over 25%	1	Del.			
20-25%	5	Colo.	D. C.	Mich.	
		N.H.-Vt.	(one plan)		
10-20%	11	Cal.	Mass.	Mont.	Mo.
		N. Y.	N. Car.	Ohio	Ore.
		Tenn.	Wis.	Wash.	
5-10%	15	Ala.	Ariz.	Conn.	Fla.
		Iowa	Ind.	Kan.	Min..
		Neb.	N. J.	Okla.	Pa.
		Va.	W. Va.	Wyo.	
Under 5%	10	Ark.	Idaho	Ill.	Ky.
		La.	Miss.	N. M.	N. Dak.
		Tex.	Utah		
No Blue Shield Plan	7	Ga.	Me.	Md.	Nev.
		R. I.	S. Car.	S. Dak.	

* According to data released by the Committee for the Nation's Health.